Restriction of Use & Disclosure Request Form

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid ID # or Soc. Sec. #

Restriction Type and Time Period

I am requesting alternatives or limitations relating to: ❒ Communication to me ❒ Disclosure to others

(Put an "X" in the box(es) that apply(ies)

List in the spaces below the time period you want the requested restriction(s).

From: _____ To: _____

I am requesting the Department of Health and Hospitals to restrict communication and/or the use and disclosure of my health information as explained below:

I acknowledge that I have read both pages 1 and page 2 of this form.

_____ _____

Signature of Individual or Personal Representative Authorized by Law — Date

_____ _____

Signature of Witness (If signed with "X" or mark) — Date

For DHH Use Only

Date received: _____ ❒ Accepted ❒ Denied ❒ Delayed

If **denied** or **delayed**, explain below.

_____ _____

Signature & Title of Agency Representative — Date

Your Right to Request Restrictions

- You have the right to request limited uses and disclosures of your personal health information held in DHH files. You may also request alternative ways for us to communicate with you. We will consider your request but we do not have to agree to your request.
- You have a right to have an answer to your request within 60 days. If there are delays in getting you the answer, you will receive a notice in writing. The delay cannot be more than 30 days.
- We may need your authorization to use and disclose information for some services. Without your authorization, DHH may not be able to see if you qualify for services.
- Your request and the answer will be kept in your record.
- If DHH agrees to your request, the restricted information will not be used or disclosed.
- DHH may end its agreement to your restriction if you ask to agree to end the restriction. Your request and DHH action will be in writing and placed in your record.
- If the restriction is ended, information in our records that was created or received while the restriction was in place will remain subject to the restriction.

Your Right to File a Privacy Complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

State of Louisiana
Department of Health and Hospitals

INSERT PROGRAM OFFICE INFORMATION HERE INCLUDING EMAIL ADDRESS

Phone: ( )
E-mail: Privacy-DHH@la.gov